NEW PATIENT QUESTIONNAIRE

Please fill out the following sections of this questionnaire as fully as you can, in **BLOCK CAPITALS AND CLEARLY** and then hand it back to Reception. Any information supplied on this form is strictly confidential.

NEW PATIENT CHECK DATE _____ PROOF SEEN? YES / NO name of person registering :

Last name: …… First name: ……..

Date of birth: …….. Male/Female (circle one)

Other family members registered at the practice including parents (names/relationship) ……
……..

Ethnicity: White – British □ White – Other □ Black African □ Black Caribbean □

Asian – Indian/Bangladeshi/Pakistani/Chinese/Japanese/Korean/Other (please circle) □……..

Mixed - White British/Black African □ Mixed – White British/Black Caribbean □

Mixed – White/Asian □ Mixed – White/Black Other □

Mixed - Other □ …….. Other (not specified) □ Rather not disclose □

Languages spoken: …….. English spoken: Yes / No (circle one)

Occupation: …… Marital Status (circle one): Single/Married/Divorced/Widowed

Telephone: (h)…… (w)…… (m)……

Email address: ……

Emergency contact: (full name/relationship): ……

Contact numbers: (h)…….. (w)…… (m)……..

Next of Kin: (full name / relationship): ……..

Contact numbers: (h)…….. (w)…… (m)……

Nominated pharmacy (for electronic prescribing): ……

Are you a carer (unpaid)? (please circle) Y/N If yes, for whom?……

Do you have a carer? (please circle) Y/N If yes, please provide carer details (name/contact no) :

……

Medications: Please bring details of any medications / health issues to your Health Check Appointment with the Nurse.

Do you have any food or drug allergies (include reactions, if known)? ……
……

CHILDREN UNDER 5 YEARS OLD:

***VACCINATIONS*:** Please provide Red Book or attach copies of any overseas vaccination records.

CONSENT FOR INFORMATION SHARING

SYSTM ONE: IT CONSENT TO SHARE INFORMATION

To share your clinical record with authorised healthcare professionals involved in your care. You will always be asked for your permission before anybody looks at your shared medical record.

I am happy to allow this information to be shared □

I do not want this information shared □

SUMMARY CARE RECORDS (SCR)

SCR is an electronic record that only allows the following three aspects of your records to be shared: allergies, adverse reactions and medications. This will make it easier for you to receive prescriptions from doctors outside the practice, should you require them. No other clinical data is uploaded.

I am happy to allow this information to be shared □

I do not want this information to be shared □

SMS TEXT MESSAGES

Are you happy for the surgery to send you health or surgery related text messages and appointment reminders on your phone. Please tick below for your consent.

I am happy to allow this information to be shared □

I do not want this information to be shared □

FOR CHILDREN AGES 13 – 16

If a parent or guardian of a child aged 13- 16 wishes to allocate their mobile number to their child's records, please ask the child to sign below to allow their consent to do this.

Name of Child_____ signed by child_____

I am happy for my parent/s to allocate their mobile number on my records until I am 16 □

I **do not** consent to the above □

ONLINE SERVICES

I would like to have access to online services via Systmone Online to book my appointments, order my prescriptions and view my detailed medical records. You will need to be responsible to keep your log in and password safe at all times.

Yes I would like access to online services □

No I would not like access to online services □

I confirm that the information provided in this form is true and accurate to the best of my knowledge.

Full name of patient (please print): ……

Date of birth of Patient: ……

Signed by: (Name of Parent/Guardian – if signing for Child under 16) ……

Signature: …… Date……

THE AVENUE SURGERY

102 The Avenue, Ealing, London W13 8LA

Please sign our patient practice contract below:

Our promise to our patient is to:

- Treat you with respect and courtesy at all times
- Provide you with advice and treatment in a timely manner
- Help you make decisions about your health.
- Treat you as an equal and with dignity at all times
- Discuss your treatment with experts and refer you when necessary
- Guide you through the health and social services
- Ensure we maintain confidentiality with what we discuss and keeping your records secure and safe.
- Keep up to date with development in health care by continuing to learn and ensure our staff are trained to optimum levels to provide you with high levels of care and support
- Treat you with compassion and to enhance your care while you are with us

In return we ask you the patient to:

- Keep your appointments and let us know if you cannot attend an appointment
- Use the out of hour's service only for an urgent medical condition which cannot wait until the next working day
- Be courteous to our staff who do the best they can for you. "Please" and "Thank you" would be the perfect way to support them
- Talk to us about complaints, suggestions, compliments to ensure we can develop as a surgery
- Register online for access to your clinical notes so you can print and download your results
- Remember to complete the Friends and Family feedback card available at the reception desk

I acknowledge the above with regard to my role as the patient of this surgery

NAME OF PATIENT_____ **DATE**_____

SIGNED _____